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**COURT OF APPEALS DIVISION II OF THE STATE OF WASHINGTON**

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AKBERET TEKLE,

Appellant,

v.

STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES,

Respondent.

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# APPELLANT'S REPLY BRIEF

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## I. ARGUMENT

### A. Standards of Neglect.

As discussed in detail in Appellant's Opening Brief (hereinafter "Op. Br."), the second subsection of the "neglect" formulation requires "…(b) an act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety… ." RCW 74.34.020(16). Under this standard, simple negligence is not enough, and no arguments from hindsight or based on bad outcomes are permissible.

Even though the Board concluded otherwise (*see* AR 24-26), DSHS argues that *Brown v. Dep't of Soc. & Health Servs.*, 190 Wn. App. 572, 360 P.3d 875 (2015), is inapplicable to this case because "Ms. Tekle and Larry are not related, no fundamental right to parent is implicated, and Ms. Tekle received funding as Larry's caregiver and licensee of the adult family home in which he resided." Department's Response Brief

(hereinafter "Resp. Br."), at 24.

This argument is plainly wrong. Although *Brown* interpreted the neglect provision of the Abuse of Children Act (ACA), the relevant definition – that of "negligent treatment or maltreatment" - was nearly identical to the Abuse of Vulnerable Adults Act (AVAA) neglect definition at issue here. *Brown*, 190 Wn. App. at 588-589 (citing former RCW 26.44.020(16)).[1] The Supreme Court has already rejected DSHS's argument here, reasoning that both statutes share a "similar structure and purpose", and therefore the analysis of the ACA guides a court's analysis of the AVAA. *Kim v. Lakeside Adult Family Home*, 185 Wn.2d 532, 543-44, 374 P.3d 121 (2016). *See also Pal v. Dep't of Soc. & Health Servs.*, 2019 Wash. App. LEXIS 489, at *27-28 (March 5, 2019) ("Given former RCW 26.44.020(16)'s nearly identical definition of 'negligent treatment,' it would have been reasonable for the Board to consider cases such as *Brown* in

[1] The same definition of "negligent treatment or maltreatment" is now at RCW 26.44.020(18). *See also* 2019 c 172 § 5.

determining what qualifies as neglect as defined under RCW 74.34.020.")

Even the decision cited by DSHS, *Woldemicael v. Dep't of Social & Health Servs.*, 19 Wn. App. 2d 178, 494 P.3d 1100, 2021 Wash. App. LEXIS 2250 (2021) (published in part), merely held that that "the Board did not err by declining to apply *Brown*" to a vulnerable adult neglect case. *Woldemicael*, 19 Wn. App. 2d at 183. *Woldemicael* also held that "serious disregard requires more than simple negligence." *Ibid.*

As such, DSHS resorts to hyperbole when claiming that "…applying *Brown* to vulnerable adult neglect would result in significantly increased risk to the elderly and disabled citizens of Washington. Doing so would arguably require proof of an intentional omission to meet the 'serious disregard' standard (which the court in *Brown* equates to 'reckless disregard')." Resp. Br., at 24 (citing *Brown*, 190 Wn.2d at 590). This overdone argument misunderstands *Brown*, and common sense alone tells us that interpreting "neglect" to require culpable

conduct well beyond simple negligence is hardly tantamount to requiring an "intentional omission."

DSHS also attempts to distinguish *Raven v. Dep't of Soc. & Health Servs.*, 177 Wn.2d. 804, 306 P.3d 920 (2013), citing specific factual variances. Resp. Br., at 26-27. However, Ms. Tekle primarily cited *Raven* for its general principle: even if an alleged perpetrator failed – in numerous respects - in her duty to meet applicable professional standards this is not sufficient to prove statutory neglect. *See Raven*, 177 Wn.2d at 829-830.

In this regard, the unpublished Court of Appeals decision in *Hu Yan v. Pleasant Day Adult Family Home, Inc., P.S.*, 2013 Wash. App. LEXIS 2830 (December 16, 2013) is especially instructive. *Yan* involved claims for damages by the husband of an adult family home (AFH) resident who died from injuries suffered in a fall after the resident "escaped" from the AFH, including a claim for neglect of a vulnerable adult under RCW 74.34.200(1). In fact, the resident was known to have "exit-seeking behavior"; and the fatal incident was not the first time

that the resident eloped from the AFH and fell. *Yan*, 2013 Wash. App. LEXIS 2830, at *1-2, 4. During trial, a DSHS investigator testified that, "even though [the AFH provider] didn't act in the way that would have benefitted this resident," the investigator nonetheless "did not find that it met the standard of neglect." *Id.*, at *18-19 (alteration supplied). *Yan* thus illustrates, on substantially similar facts, the significant amount of daylight that exists between conduct which fails to comply with an AFH provider's duty of care and acts or omissions which rise to the higher level of statutory neglect.

**B. Larry's Primary Care Provider Supported Ms. Tekle.**

As part of an apparent effort to portray as exceptional and unreasonable Ms. Tekle's assessment of Larry's abilities and his relative safety at the time of the subject incident, DSHS repeatedly attempts to diminish and discredit the supportive statements and testimony of Larry's primary care provider (PCP), Melissa Paul, FNP-C, MSN. As outlined in the Opening

Brief, the Adult Protective Services (APS) case notes reflect that Ms. Paul expressly told the APS investigator that "[Larry] no longer uses a walker; [Larry] is mobile and does not need extensive physical assist. *[Larry] informed the PCP of incident and PCP believes [Larry] is able to be out in the community alone without assistance of a caregiver*." AR 254 (alteration supplied; emphasis added). Nowhere in the Response Brief does DSHS directly confront this opinion.

Instead, DSHS avers that "[i]t appears that, at that time, Investigator Haertel may have believed Melissa Paul was Larry's doctor rather than *his attending nurse*, as casenotes reflect that she left a message for Larry's 'PCP Dr. Melissa Paul.' " Resp. Br., at 16-17 (emphasis added). Elsewhere, DSHS omits Ms. Paul's higher credential, inappropriately referring to her as "Registered Nurse Melissa Paul." *Id.*, at 42. DSHS thus seems to imply that Ms. Paul's qualifications should render her opinions less significant, and/or that she was not actually Larry's PCP. However, Ms. Paul clearly testified to her credentials as a

licensed family nurse practitioner with decades of prior experience as a Registered Nurse. RP Vol. III, at 10-11. She also clearly stated that Larry was "[her] patient," and that she had seen him many times. *Id.*, at 11-12. No higher-licensed witness testified in support of DSHS. There was no reason to disregard or demean the value of Ms. Paul's opinions regarding Larry's abilities as of the date of the incident.

DSHS repeatedly cites the fact that Larry "missed" his Lactulose medication on August 6, misleadingly suggesting that "his judgment could be affected if he did not take his Lactulose… ." Resp. Br., at 11, 17, 48.[2] While citing generically to Ms. Paul's "opin[ion]", DSHS does not mention that her specific testimony was that "Larry does not have cognitive diagnosis with impairment with the exception of an elevated liver enzyme that has made him irritable and angry, but still able to voice his

[2] DSHS also omits mention of the fact that Larry *refused* to take the Lactulose that morning, out of concern that it would cause him to have excessive bowel movements. *See* RP Vol. II, at 69-71.

needs." RP Vol. III, at 17. Certainly, Ms. Paul did not opine that Larry's missing one dose of Lactulose put him at risk of immediately onsetting impairment of judgment. Nor did any other witness offer that opinion.

**C. Repeated Arguments from Hindsight.**

While DSHS argues that there was substantial evidence supporting the neglect finding even without reference to the August 29, 2019 interim negotiated care plan (hereinafter "August NCP"), it does not defend the Board's argument from hindsight that "[Ms. Tekle's] argument is defeated as well because 20 days after the movie incident, she created and signed an NCP that was even more restrictive and prescriptive regarding Larry's ability to go into the community and to the movie theater." AR 23 (alteration supplied). Nor does DSHS address the fact that, in addition to being a retrospective argument, this conclusion runs counter to the logic of Evidence Rule 407, which provides: "[w]hen, after an event, measures are taken which, if taken previously, would have made the event less likely to occur,

evidence of the subsequent measures is not admissible to prove negligence or culpable conduct in connection with the event." ER 407. This Rule applies even in cases alleging strict liability. *Hyjek v. Anthony Indus.*, 133 Wn.2d 414, 944 P.2d 1036 (1997).

Instead, DSHS attempts to divert the discussion of the Board's inappropriate reliance on the August NCP by claiming that this was done only "in support of its finding that Ms. Tekle's testimony that Larry was capable of safely functioning in the community independently was not credible, and that her position was unjustified." Resp. Br., at 37 (citing AR 13-14, 23). DSHS's own record citation belies the suggestion that the Board's reliance on the August NCP was so limited, as it includes the Board's legal conclusion as to the "act or omission" element of neglect, which in turn incorporates the argumentative hindsight-based analysis cited above.

**D. DSHS's Misconception of NCPs.**

Echoing the flawed analysis of the Board, DSHS's Response Brief argues at length that any "violation of" – or

deviation from - the May 14, 2019 negotiated care plan (hereinafter "May NCP") represents presumptive evidence of neglect. *See* Resp. Br., at 34-38, 40-44. As discussed in the Opening Brief, this fundamentally misconstrues the nature and purpose of an NCP, which is not intended to be a listing of prohibited conduct. *See* Op. Br., at 37-38.

DSHS's maximalist interpretation of the consequences of a "violation of" an NCP would greatly expand the potential for punitive actions against AFH providers based on ad hoc failures to adhere to a plan. AFH regulations already provide for a citation for a provider's failure to "…ensure each resident receives: (1) The care and services identified in the negotiated care plan." *See* WAC 388-76-10400 (Care and services.) Indeed, this deficiency was cited in Ms. Tekle's case. *See* AR 295. DSHS data indicate that the "care and services" regulation is among those most frequently cited by DSHS during its inspections and complaint investigations. In fact, during the third quarter of 2019 alone (when the subject incident occurred)

DSHS cited this same regulation 72 times.[3] To be sure, DSHS did not substantiate a finding of neglect against the AFH provider in every such case. It is simply unreasonable to interpret the May NCP as DSHS suggests.

The foregoing discussion should also make it clear that, contrary to DSHS's erroneous suggestion, it is not Ms. Tekle's argument that "[t]he care and services to be provided in a NCP" are merely "permissive." Resp. Br., at 43. Again, the issue is the consequences which may flow from an AFH provider's almost inevitable failure to follow every aspect of an NCP at any given point in time.

Further, while DSHS does not address Ms. Tekle's

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[3] *See* https://www.dshs.wa.gov/sites/default/files/ALTSA/rcs/documents/2019%20Q3%20--%20Top%20AFH%20Citations.pdf

During the same quarter, another AFH regulation repeatedly cited by DSHS in the Response Brief, WAC 388-76-10355 (Negotiated care plan), was cited 120 times, making it the single most frequently cited deficiency. *See id.*

arguments related to the elimination of the historical doctrine of negligence per se (*see* Op. Br., at 48-49), it still seems to suggest that the Board permissibly "concluded that Ms. Tekle committed negligence per se,… ." Resp. Br., at 38. Whether this reference was intentional or not, for reasons discussed in the Opening Brief and above, a conclusion of "*neglect* per se" based on actual or potential violations of AFH regulations is clearly erroneous.

Also, as noted in the Opening Brief, the May NCP did not accurately reflect Larry's abilities and limitations as of August 2019.[4] NCPs are intended to be fluid and subject to revision based on discussions between the caregiver and the resident and/or the changing conditions and needs of the resident. *See*, *e.g.*, WAC 388-76-10380 (Negotiated care plan—Timing of reviews and revisions.) In this case and others, the terms of a NCP may not accurately reflect whether, at some future point in time, the failure to provide a certain item of care or services

[4] Even the APS investigator agreed that "there are aspects of the CARE plan…that needed to be updated." RP Vol. I, at 48.

"demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety," as is required for a finding of neglect.

DSHS also argues that "[d]uring the administrative hearing, Ms. Tekle testified that Larry's NCP allowed him to arrange and use transportation on his own, *contrary to the plain language of the NCP*." Resp. Br., at 16 (emphasis added). Here, DSHS cites to a page from the August NCP, not the May NCP which it otherwise argues was operative. *Ibid.*[5] As noted in the Opening Brief, the May NCP was ambiguous as to whether Larry could arrange for and use transportation without direct supervision. *See* Op. Br., at 36, n. 14.

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[5] Moreover, the cited page states that "*Caregiver will assist Resident to make transportation arrangements to go to movies as able*. With CVAN or Medical Transport, Caregiver will set up CVAN or Medical Transport. Caregiver will ensure Resident does not go anywhere by himself *unless with CVAN or Medical Transport*." AR 189 (emphasis added). Thus, even the post-incident August NCP was more ambiguous and less "plain" than DSHS suggests.

In any event, while the May NCP stated that Larry "likes to go to the movies" and that the "[c]aregiver will assist Resident to make transportation arrangements to go to movies *as able*," AR 286 (emphasis added), this does not mean that Ms. Tekle was obligated to personally escort or transport Larry whenever he wanted and/or without having advance notice. In addition, "transportation arrangements" was not defined and therefore the May NCP did not specifically exclude the possibility of arranging for bus transit.

DSHS argues in plain error that "…the record does not reflect that Ms. Tekle assisted Larry in planning the bus route in any capacity,… ." Resp. Br., at 41. To the contrary, Ms. Tekle testified that Larry "told me he already knew what bus he needed to take to get there;" that he "told me the time of the bus he takes…and everything;" and that she "was also able to ask him questions to make his plans clear to me." RP Vol. I, at 95; Vol. II, at 58.

**E. "Allowing" Larry to Leave.**

As discussed in the Opening Brief, The Board never acknowledged that Larry was entitled to freely exercise various rights under Chapter 70.129 RCW; or that Ms. Tekle was legally prohibited from physically restraining him. Op. Br., at 33-35. It is not disputed that Ms. Tekle attempted several times to persuade Larry not to leave, but he refused to comply. Moreover, as the only caregiver on duty at the time, Ms. Tekle could not, consistent with the duties she owed to the other residents, leave Orchard's to escort Larry after he had decided to depart. These legal constraints greatly curtailed the effective options that Ms. Tekle had to prevent him from leaving.

Just as the Board did, DSHS's Response Brief totally ignores the dilemma posed by these constraints. DSHS offers no discussion of what lawful acts Ms. Tekle could have undertaken so as to *not "allow"* Larry to leave. Instead, DSHS just repeats ad nauseum and without further explanation variations of the word "allowed." Resp. Br., at 1, 2, 3, 17, 20, 25, 34, 36, 40, 58.

The foregoing considerations also rebut DSHS's analysis of causation. *See* Resp. Br., at 27-29. As noted in the Opening Brief, APS's own internal policy manual requires that it establish that the alleged act or omission of the alleged perpetrator is a proximate cause of the actual or potential harm suffered by the alleged victim. Op. Br., at 30-31. Put in the colloquial terms of the APS Manual, DSHS must have answered the question of "[w]hat should have occurred, but did not happen?" *Ibid.* Given the limitations imposed by applicable law establishing Larry's freedom to exercise his rights and to be free from physical restraints, DSHS failed to show what more Ms. Tekle "should have" done to prevent Larry from leaving on his own. For these same reasons, Larry's own volitional acts clearly constituted the proximate cause of any potential harm that he faced.

**F. Due Process Interests.**

DSHS's discussion of *Ryan v. Dep't of Social & Health Servs.*, 171 Wn. App. 454, 287 P.3d 629 (2012), skirts the Court's clear holding that constitutional rights are implicated in

APS abuse/neglect findings and related proceedings since it is "clearly established that State action that imposes a stigma that alters an individual's eligibility to exercise rights under state law or to work in a chosen field implicates protected liberty interests." *Ryan*, 171 Wn. App. at 472 (citations omitted).[6] Given this precedent, DSHS's related argument that Ms. Tekle "does not provide a legal basis to support her position" (Resp. Br., at 30) is baseless.

DSHS attempts to distinguish *Ryan* on the basis that it involved a situation of a misdelivered notice that was not

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[6] Elsewhere, DSHS cites in error *Goldsmith v. Dep 't of Social & Health Servs.*, 169 Wn. App. 573, 280 P.3d 1173 (2012), for the proposition that "[t]he purpose of APS findings is not punitive… ." Resp. Br., at 25. In fact, *Goldsmith* says nothing about whether APS findings are "punitive," or not. However, the Court of Appeals has held that APS findings may amount to "punitive action." *See Crosswhite v. Dep't of Soc. & Health Servs.*, 197 Wn. App. 539, 552, 557, 389 P.3d 731 (2017). *See also Pal*, *supra*, 2019 Wash. App. LEXIS 489, at *25 ("Pal argues, accurately, that the AVAA has both beneficial and punitive purposes.") This Court has also held that APS findings are "professionally disqualifying," "permanent" and "severe." *See Crosswhite*, 197 Wn. App. at 545-546; *Woldemicael*, *supra*, 2021 Wash. App. LEXIS 2250, at *17.

received by the appellant, resulting in the dismissal of her appeal. *Id.*, at 31-33. This point is taken, but Ms. Tekle relies on *Ryan* for its broader recognition of the right of "alleged perpetrators" to have their liberty interests protected from DSHS/APS infringement, absent due process of law. Ms. Tekle submits that she was deprived of due process because of the erroneous, arbitrary and capricious conduct of DSHS and the Board in the investigation and adjudication of her case including: wrongfully refusing to accept the statements and testimony of Ms. Paul as to Larry's abilities and limitations at the pertinent time; misinterpreting and relying upon outdated documents and records; refusing to consider compelling evidence; and failing to follow to applicable Court of Appeals decisions.

**G. Arbitrary and Capricious Conduct.**

As discussed in detail in the Opening Brief and above, DSHS and the Board engaged in irrational and willful conduct including: wrongfully refusing to accept the statements and testimony of Ms. Paul as to Larry's abilities and limitations at the

pertinent time; misinterpreting and relying upon outdated documents and records; refusing to consider compelling evidence; and failing to follow to applicable Court of Appeals decisions.

The generalized standards of deference cited by DSHS (*see* Resp. Br., at 49-50) do not excuse such irrational and willful conduct. Further, as detailed above, there is and was no rational basis for DSHS to belittle the credentials of Ms. Paul or disregard her opinions. *See supra*, at 5-8. DSHS's actions were arbitrary and capricious.

**H. Attorney's Fees Under EAJA.**

In that event that Ms. Tekle prevails, the Court should authorize an award of fees and costs, including reasonable attorneys' fees pursuant to RAP 18.1 and RCW 4.84.350, for the proceedings before the Superior Court and Court of Appeals.

"To be entitled to an award of attorney fees under the EAJA, a qualified party is deemed to have prevailed if that party obtained relief on a significant issue." *ZDI Gaming, Inc. v. Wash.*

*State Gambling Comm'n*, 151 Wn. App. 788, 813, 214 P.3d 938 (2009), aff'd, 173 Wn.2d 608, 268 P.3d 929 (2012). In *Karanjah v. Dep't of Soc. & Health Servs.*, 199 Wn. App. 903, 401 P.3d 381 (2017), this Court found that an award of fees under the EAJA was appropriate where the Board made an arbitrary and capricious finding of abuse. *Karanjah*, 199 Wn. App. at 926-927.

Ms. Tekle simply disagrees with DSHS's suggestion that its actions were "substantially justified." They were not. Ms. Tekle should be deemed eligible for an EAJA fee award if she prevails.

## II. CONCLUSION

For the reasons discussed above and in the Opening Brief, the Final Order and the neglect finding against Ms. Tekle should be vacated and reversed.

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I hereby certify that this document, exclusive of the portions designated in RAP 18.17(b), contains 3,444 words.

DATED this 24th day of June, 2022.

LYBECK PEDREIRA & JUSTUS, PLLC

By: 
Benjamin Justus (WSBA #38855)

*Attorneys for Appellant*

## CERTIFICATE OF SERVICE

I hereby declare under penalty of perjury under the laws of the State of Washington that I have caused to be served a true and correct copy, except where noted, of the below described documents upon the individual(s) listed by the following means:

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